U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 15 April 2005

In the Matter of:

RICHARD A. BUNCH,
Claimant

v.

LAUREL FORK MINING, INC.,
Employer

and

AMERICAN CASUALTY COMPANY
OF READING PA,
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Case No.: 2003-BLA-6683

Appearances:

Ron Carson, Program Director
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

Timothy W. Gresham, Esq.
Penn Stuart
Abingdon, Virginia
For the Employer/Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, Richard A. Bunch, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on January 14, 2004, in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, the Claimant was the only witness. Transcript ("TR") 17-31. Director's Exhibits ("DX") 1-34 and Claimant's Exhibits ("CX") 1-3 were admitted without objection. Employer's Exhibits ("EX") 1-10 were admitted into evidence after discussion of whether they exceeded the limitations contained in the rules.[1] The record was held open for the Claimant to submit additional evidence (over the Employer's objection, *see* TR 9-10), and both parties to submit optional closing arguments. TR 8-10, 32. Dr. Alexander's interpretation of the chest x-ray dated November 24, 2003, submitted under cover of letter dated January 30, 2004, has been marked and received in evidence as CX 4. In addition, I have received and considered Employer's Closing Argument, which was submitted under cover of letter dated March 3, 2004. Claimant's lay representative provided an oral closing argument at the end of the hearing. TR 32-33. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony presented, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on March 18, 1991. DX 1, formerly DX 22 (DX 31). The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on September 3, 1991, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The Claimant did not appeal that determination. DX 1.

[1] The Claimant's representative stated that he had no objection to the Employer's exhibits so long as they were within the limitations of the regulations. TR 11. The Claimant specifically objected to EX 7. TR 12-13. After discussion, I ruled that it was within the limitations, i.e., that both parties were entitled to submit a re-reading of the x-ray taken on behalf of the Department of Labor, which was initially read as negative, but the Complainant objected to my interpretation of how the rule regarding "rebuttal" should be applied. TR 13-16.

More than one year later, on October 12, 1993, the Claimant filed a duplicate claim. DX 1, formerly DX 22 (DX 1). The duplicate claim was denied by the District Director on July 20, 1995, who found that the Claimant had failed to show a change in conditions. The Claimant appealed that determination, but it was dismissed after he failed to appear at the hearing. DX 1.

The Claimant filed another duplicate claim on July 31, 1997. Administrative Law Judge Mollie Neal held a hearing on the claim on February 24, 1999, and denied benefits in a decision issued on August 23, 1999. Judge Neal found that the Claimant had established a change in conditions since his previous claim was denied, as he had shown that he was totally disabled. She also found, however, that he had failed to show that he had pneumoconiosis, or that it caused his disability. The Benefits Review Board affirmed Judge Neal's decision on October 27, 2000. DX 1.

The Claimant filed his current claim on June 10, 2002. DX 3. The Director issued a proposed Decision and Order denying benefits on June 26, 2003. DX 30. The Claimant appealed on July 7, 2003. DX 31. The claim was referred to the Office of Administrative Law Judges for hearing on September 23, 2003. DX 34.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on June 13, 2002. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). Pursuant to 20 CFR § 725.309(d) (2004), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

In the previous claim, Judge Neal found, and the BRB affirmed, that the Claimant had established that he was totally disabled by a pulmonary or respiratory impairment, but not that it was caused by pneumoconiosis. In order to show a change in conditions and entitlement to benefits, the Claimant must show that he has pneumoconiosis as defined by the Act and regulations. For the reasons stated below, I have concluded that the Claimant has failed to demonstrate that he has pneumoconiosis. Thus I will address only the medical evidence from his current claim in this decision, except insofar as the evidence from a prior claim sheds light on that in the current claim. Under 20 CFR § 725.309(d)(4), no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. Both the Employer/Carrier, and the Director, OWCP, contest the issue of disability in this claim. As neither stipulated disability in a prior claim, this issue is properly before me.

ISSUES

The issues contested by the Employer and the Director are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the evidence establishes a material change in conditions pursuant to 20 CFR §725.309.

The Employer also reserved its right to challenge the application and validity of the regulations. The Employer stipulated that the Claimant had at least 13.5 years of coal mine employment. DX 34; TR 5-6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant, Richard A. Bunch, testified at the hearing before Judge Neal, as well as the hearing before me. He was born in 1953, and was 50 years old at the time of the second hearing. He has a ninth grade education, but testified that he received a high school diploma through a vocational school. He has no dependents for the purpose of potential augmentation of benefits under the Act. DX 3; DX 34; TR 17.

Mr. Bunch's estimates of his coal mine employment have varied from 14-16 years in his various claims. The parties stipulated to at least 13 ½ years of such employment. TR 5. As Mr. Bunch had more than ten years in the mines, any discrepancies in the exact number of years of coal mine employment are inconsequential for the purpose of rendering a decision. His last usual coal mine job involved some supervisory duties, but also work as a high lift operator. He testified that the job entailed considerable lifting and physical exertion. TR 18-19. On a Description of Coal Mine Work and Other Employment form, dated August 13, 1997, Mr. Bunch listed his job title as "Coal Miner – High Lift Operator – Foreman." DX 1, formerly DX 4. On a more recent Description of Coal Mine Work and Other Employment form, dated May 28, 2002, he reported his job title as "Supervising Miner." DX 5. However, on both occasions, Mr. Bunch described the activities required by the job as including sitting, but also requiring extensive crawling and some lifting and carrying. DX 1, formerly DX 4; DX 5. Taken as a whole, I find that Claimant's last coal mine job entailed periods of moderate to heavy manual labor. His last coal mine employment was in Tennessee. TR 26. Therefore this claim is governed by the law of the 6th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Mr. Bunch testified that he stopped working in 1988 because he had difficulty breathing, and his physician told him to retire. He said he first noticed his breathing problem in the late 1970's or 1980. TR 21-22. On cross-examination, he was asked whether he was told that he suffered from Kartagener's Syndrome and/or bronchiectasis. However, he apparently did not understand either of those terms. Mr. Bunch did acknowledge, however, that he underwent two lung surgeries in the early 1970's, when he was in his late teens. Moreover, he testified that, in one operation, 80% of his lung was removed; and, in the other operation, 20 percent of his other lung was removed. TR 30.

Mr. Bunch testified that he had been treated by Dr. Hembee for his lungs and a bad heart. Dr. Hembee was the physician who reportedly told him to retire. TR 22. However, Mr. Bunch is currently being treated by Dr. Jordan. Mr. Bunch estimates that he has been seeing Dr. Jordan for ten or more years. TR 22-23. In addition to taking Ambien for sleeplessness, he has two or three breathing treatments per day, and also uses an inhaler and/or nebulizer. He testified that, in 1988, he couldn't work. Furthermore, he stated that his breathing condition has worsened since then. TR 23-24.

Mr. Bunch acknowledged that he began smoking cigarettes when he was in high school. At that time, "probably a pack would last you three or four weeks." However, his daily cigarette consumption subsequently increased. Although Claimant testified that he periodically stopped smoking, he stated that he finally quit smoking altogether about six or seven years ago. When asked the average he smoked per day when he was smoking, Claimant stated: "maybe a half a pack or a pack a day, or something, I don't know." TR 30-31. His medical records indicate that he smoked a pack a day beginning in 1970, and quit in 1997. Based on all the evidence, I find that he has about a 25 pack-year smoking history.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004). One such reading is therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications for physicians who read x-rays in connection with the claim for benefits have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH). [2] Qualifications of physicians are abbreviated as follows: B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/11/86			DX 13 Hicks (Reason for exam not given. Dextrocardia with situs inversus. Right basilar infiltrate. Lungs otherwise clear.)
09/21/88			DX 13 Pflanze (Preoperative x-ray. Irregular densities both lungs. Findings compatible with Kartagener's syndrome.)
09/24/97			DX 13 Jordan (DOL evaluation. Improvement in interstitial and parenchymal lung disease due to smoking cessation. Continued bronchiectatic changes bilaterally. No change in pleural thickening.)

[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
01/05/99			DX 13 Jordan (Worsening cough and sputum production. Mild improvement in interstitial changes due to reduced smoking with decreased bronchiolitis)
05/09/02	DX 11 Ahmed (B, BCR) 1/1 DX 11, DX 14 (corrected copy) Alexander (B, BCR) 1/2	EX 3 Scott (B, BCR) EX 4 Scatarige (B, BCR)	
08/23/02	CX 1 Aycoth (B, BCR) 1/1	DX 10 Baker (B) 0/1 EX 7 Wheeler (B, BCR)	DX 10 Goldstein (B) Read for quality only. Quality 3 = poor
02/14/03		EX 2 Hayes (B, BCR)[3]	DX 12 Hughes (Total situs inversus with diffuse bronchiectatic changes. Granulomas. Minimal pleural thickening.)
04/04/03	DX15 Ahmed (B, BCR) 1/1	DX 13 Wheeler (B, BCR)	
11/24/03	CX 4 Alexander (B, BCR) 1/2	EX 6 Wheeler (B, BCR)	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991).

A CT scan of the thorax was conducted at Methodist Medical Center on February 17, 2003. Dr. William K. Prater, who is listed as the "Radiologist" but whose credentials are not otherwise noted, reported the following findings:

[3] The Claimant did not object to admission of this x-ray at the hearing. Upon reflection, I conclude that its admission was improper because it exceeds the limitations contained in the regulations, as the x-ray in question was taken as part of Mr. Bunch's medical treatment, and was not designated by the Claimant as one he relied on under 20 CFR § 725.414. My conclusion that the x-ray evidence does not establish the existence of pneumoconiosis would be the same, whether or not this x-ray reading is considered.

Axial sections are obtained through the thorax without contrast, which demonstrates the heart to be right sided and the liver to be left sided. NO significant mediastinal lymphadenopathy or mass is identified. There is some apparent enlargement of a left sided azygos lymph node. Evaluation of lung windows demonstrates some nonspecific pleural and parenchymal scarring. There is also evidence of bronchiectasis in the lung bases and in the middle lobe, which is left sided.

IMPRESSION:
SITUS INVERSUS AND BRONCHIECTASIS COMPATIBLE WITH KARTAGENERS SYNDROME.

DX 12.

Dr. John C. Scatarige, a B-reader and Board-certified radiologist, EX 4, reviewed the CT scan of the chest, dated February 17, 2003. In his report, dated August 7, 2003, Dr. Scatarige stated, in pertinent part:

Results:

1. No evidence of CWP or silicosis.
2. Complete situs inversus.
3. Bronchiectasis in left mid-lung and both lung bases with inspisated secretion/mucous in the dilated bronchi.
4. All findings compatible with Kartagener's syndrome. Is there a history of sinusitis? Left apical pleural thickening.

EX 5.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 11 05/09/02 Narayanan	48 72"	1.08	2.75	39%	39	Yes	Severe obstruction, possible concomitant restrictive defect.
DX 10 08/23/02 Baker	48 72"	1.31	4.19	31%	31	Yes	Severe obstructive defect. Acceptable study per Dr. Michos.
DX 13 04/04/03 Dahhan	49 188 cm. (74"[4])	1.20 1.41	2.67 3.03	45% 46%	35 41	Yes Yes	Severe obstructive defect with partial response to bronchodilator; mild restrictive impairment.
CX 2 05/13/03 Narayanan	49 72"	1.21	3.26	37%		Yes	Very severe obstruction
EX 6 11/24/03 Hudson	50 73"	1.48	3.93	38%		Yes	Severe airway obstruction.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 72" to 74", I have taken the mid-point (73") in determining whether the studies qualify to show disability under the regulations. All of the tests are qualifying to show disability, whether considering the midpoint, or the heights listed by the persons who administered the testing.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 13	07/20/93	East Tenn. Pulmonary Associates	35.9	75.4	No	
DX 13	11/21/01	East Tenn. Pulmonary Associates	38.9	72.6	No	
DX 10	08/23/02	Baker	41	70	No	Mild resting hypoxemia.
DX 12	02/14/03	East Tenn. Pulmonary Associates	36.4	57.4	Yes	
DX 11, DX 12	03/04/03	Jordan	38.6 43.8	58 54.8	Yes	Worsening gas exchange
DX 13	04/04/03	Dahhan	38.7 45.1	62.2 59.5	No Yes	Hypoxemia at rest with desaturation upon exercise.
EX 6	11/24/03	Hudson	38.4 36.2	63 57	No Yes	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques,

concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). The record contains the following treatment records and medical opinions submitted in connection with the current claim.

Hospital records from the University of Tennessee from 1972 reflect that Mr. Bunch was referred for evaluation of his lungs at age 18. He was smoking a pack a day, having started at age 16. He was diagnosed with Kartagener's syndrome and bronchiectasis. He then underwent lung resection surgery. DX 13.

Mr. Bunch was hospitalized for a hernia repair in 1988. The discharge summary appears in EX 1 (both pages) and DX 13 (first page only). According to the social history taken at the time, he was smoking one pack of cigarettes per day. The summary mentioned that Mr. Bunch's primary physician, Dr. Henry, had consulted another doctor, Dr. Obenhour, to manage his severe lung disease; Dr. Obenhour evaluated Mr. Bunch in the hospital to optimize management of his asthma, but if Dr. Obenhour prepared a report, it is not in the record. EX 1; DX 13.

Dr. Manley M. Jordan, has been Claimant's treating physician for at least ten years, TR 23. The Employer introduced some of his notes from 1991 and 1993 into the record of the current claim. DX 13. In September 1991, Dr. Jordan diagnosed Kartagener's syndrome with probable bronchiectasis, and nasal polyps in need of surgery. He noted that Mr. Bunch was still smoking. He assessed a moderate obstructive impairment with some broncho-spasms and severe oxygen desaturation with exercise.

In May 1993, Dr. Jordan noted he had first seen Mr. Bunch in May 1991 for his Department of Labor evaluation. Mr. Bunch was still smoking. Dr. Jordan's impression was severe respiratory impairment due to severe obstructive ventilatory impairment from bronchiectasis and reactive airways disease, as well as a mild restrictive impairment due to the previous thoracotomy. X-rays taken for Dr. Jordan in 1997 and 1999 appear on the chart above, and indicate that Mr. Bunch had stopped smoking by 1997, and was showing some improvement in his lungs. The x-ray reports identify the source of his lung disease as bronchiolitis superimposed on bronchiectasis. DX 13.

Mr. Bunch has been seeing a cardiologist every few months since at least May 1997. The file contains office records from Dr. Naresh Mistry from May 1997 to August 1998, and Dr. Lech Pietrasz from January 1999 to May 2001. Mr. Bunch was hospitalized from July 18-24, 2001, for atrial fibrillation. His other diagnoses were Kartagener's syndrome with dextrocardia, chronic obstructive pulmonary disease (COPD), status post bilateral lobectomy, and a history of tobacco abuse. Mr. Bunch saw Dr. Pietrasz for follow-up in September 2001, and February and July 2002. None of the cardiologists' records include a diagnosis of coal workers' pneumoconiosis. DX 13.

On August 23, 2001, Dr. Glenn Baker, whose credentials are not in the record, examined the Claimant. On a U.S. Department of Labor report form, DX 10, Dr. Baker set forth Claimant's occupational, social, family and medical histories, and stated his findings on physical examination, chest x-ray, pulmonary function test, and arterial blood gas study. In pertinent part, Dr. Baker reported Claimant's last coal mine employment from 1982 to 1988, as a "high lift, supervisor," while also noting that Claimant "stated he was given 13 ½ years, but had worked 16 yrs., ½ of this time was underground." Dr. Baker reported that Claimant had "surgery on lungs, age 15 & 16," but did not specify how much lung tissue was removed on each occasion. In addition, Dr. Baker set forth a cigarette smoking history of only "¼ PPD" from age 20 to 42 (*i.e.,* 1973-1995). Dr. Baker reported a negative (0/1) x-ray reading. However, the pulmonary function test showed "severe obstructive defect;" the arterial blood gas study revealed "mild resting arterial hypoxemia;" and the EKG showed "normal sinus rhythm."

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Baker set forth the following diagnoses and underlying bases for such findings:

1. COPD with severe obstructive defect: PFTS
2. Chronic bronchitis: history of cough, sputum production & wheezing
3. Hypoxemia: PO2
4. Sinus ventricular tachycardia: by history

DX 10, Sec. D6. When asked the etiology of the foregoing conditions, to list the primary and secondary causes, if applicable, and provide his rationale, Dr. Baker stated the following:

1. bronchiectasis, cigarette smoking, coal dust exposure.
2. bronchiectasis, cigarette smoking, coal dust exposure.
3. bronchiectasis, cigarette smoking, coal dust exposure.
4. ? etiology

DX 10, Sec. D7. However, Dr. Baker failed to specify the underlying rationale for his conclusion regarding the etiologies of the diagnosed conditions. In response to a form question regarding the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, particularly in terms of Claimant's ability to perform his last usual coal mine job, Dr. Baker stated: "severe with decreased FEV1, decreased PO2, and chronic bronchitis." DX 10, Sec. D8a. When asked to specify the extent to which each of the diagnoses listed in D6 contributes to Claimant's impairment, Dr. Baker simply noted: "fully." DX 10, Sec. 8b.

On a separate form report, which Dr. Baker also signed on August 23, 2002, he provided confusing and conflicting responses to various questions. On the one hand, Dr. Baker reiterated that Claimant suffers from a severe impairment, which would preclude the miner from performing coal mine work or comparable work in a dust-free environment. When asked whether the pulmonary impairment is related to pneumoconiosis or does it have another etiology, Dr. Baker stated: "cigarette smoking" and "coal dust exposure." The latter, if credited would be consistent with a finding of "legal pneumoconiosis." I note, however, that Dr. Baker failed to mention bronchiectasis. More significantly, in response to the first question, Dr. Baker indicated

that, based upon his examination of Claimant, the miner did *not* have an occupational lung disease which was caused by his coal mine employment. DX 10.

Mr. Bunch consulted a neurologist about his headaches in the spring of 2002. The neurologist thought they were related to his Kartagener's syndrome, and treated him with medication. DX 13.

Mr. Bunch was examined by a nurse practitioner at the Stone Mountain Health Services St. Charles Community Health Clinic on June 3, 2002. She assessed COPD and "coal workers pneumoconiosis by history." CX 3.

On April 4, 2003, Dr. Abdul K. Dahhan, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease examined the Claimant, and reviewed his medical records. DX 13; EX 10, pp. 4-5. In his report, dated May 27, 2003, DX 13, Dr. Dahhan set forth a 16-year coal mine employment history ending in 1988, of which six was spent underground. Dr. Dahhan reported Claimant's cigarette smoking history as follows: "The patient used to smoke beginning in his teens and averaged a pack per day before quitting seven years ago at age 42." Claimant is "known to have Kartagener Syndrome with bronchiectasis post resection of 80% of one lung and 20% of the other lung in 1973 as treatment for his bronchiectasis." In addition, Dr. Dahhan noted that Claimant has frequent cough with yellowish sputum, and that he uses Proventil via a nebulizer three times per day. Claimant also complained of dyspnea on exertion. He has a history of cardiac arrhythmia, and takes Coumadin, Cardizem, Lanoxin, Atacand, Rhymol, and Ambien. Examination of the chest showed scars over both thoraces with bilateral rhonchi and wheeze. Dr. Dahhan also reported evidence of dextrocardia with regular sinus rhythm and normal tracings on electrocardiogram, a carboxyhemoglobin of .6%, abnormal pulmonary function and arterial blood gas results, and a chest x-ray interpretation of no pleural or pleural abnormalities consistent with pneumoconiosis, but which revealed emphysema, bullae formation, and post op changes with pleural thickening in both lungs. In addition, Dr. Dahhan's report, dated May 27, 2003, contains a review of other medical data. In summary, Dr. Dahhan stated:

> In conclusion, based on my examination of Mr. Bunch and my review of his medical records as described above, within a reasonable degree of medical certainty, the following conclusions can be made:
>
> 1. There are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, obstructive abnormalities on pulmonary function testing with significant response to bronchodilator therapy, and the finding of other causes for his respiratory impairment as well as negative x-ray reading for pneumoconiosis.
>
> 2. Mr. Bunch has total and permanent pulmonary disability.
>
> 3. Mr. Bunch's pulmonary disability has resulted from many factors. The most important factor is that he has bronchiectasis secondary to his congenital disease known as Kartagener's syndrome. In addition, he has obstructive airway disease

that has resulted from his length (sic) smoking habit that has been reported by all physicians and finally, he has had a thoracotomy with resection of a significant portion of his lungs including the left, middle and lower lobes, which have caused his restrictive ventilatory impairment simply by the removal of part of the lung.

4. Based on the above, I find no evidence of pulmonary impairment and/or disability in Mr. Bunch's case caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis since his respiratory impairment has resulted from other causes as detailed above.

5. Mr. Bunch's treated (sic) physician Dr. Jordan has been treating him for bronchiectasis, sinusitis and a cardiac arrhythmia. All of these conditions are related to Kartagener's syndrome, a congenital anomaly and was not caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

DX 13. Dr. Dahhan reiterated the foregoing opinion in his deposition testimony on January 6, 2004. EX 10. He explained that Kartagener Syndrome is a congenital disease associated with bronchiectasis, which is damage to the alveolar sacs, along with other manifestations. In Mr. Bunch's case, the syndrome resulted in removal of 80% of the right lung, and 20% of the left lung, causing restrictive as well as obstructive impairment. EX 10, pp. 7-10. Furthermore, Dr. Dahhan specified that Claimant does not suffer from either medical or legal pneumoconiosis. Moreover, Dr. Dahhan stated that, even if it were stipulated that Claimant has Category 1 pneumoconiosis by x-ray, such a finding would not be expected to cause the severe loss of respiratory function reflected on the pulmonary function studies and arterial blood gas tests. EX 10, pp. 18-20.

The record also contains Dr. Jordan's recent treatment notes and reports during the period from January 17, 2003 through May 9, 2003. DX 12.

On January 17, 2003, Dr. Jordan noted that Claimant had symptoms of angioedema from his ACE inhibitor, some tongue swelling and intermittent difficulty swallowing. He was switched to Atacand and his condition improved markedly. In pertinent part, Dr. Jordan reported the following findings on examination: "LUNGS: Bronchiectasis. No infective symptoms." DX 12, 1/17/03 note.

A Discharge Summary from Methodist Medical Center, dictated by Dr. Jordan on February 20, 2003, outlines Claimant's treatment during his hospitalization from February 14, 2003 to February 20, 2003. DX 12. Dr. Jordan set forth the following discharge diagnoses:

1. Bronchiectasis, exacerbated by bacterial infection with Pseudomonas aeruginosa.
2. Underlying bronchospasms.
3. History of Atrial fibrillation.
4. Kartagener's syndrome with psoatis and bursas totalis.
5. Chronic sinus disease.

Under the "Hospital Course" portion of the Discharge Summary, Dr. Jordan stated, in pertinent part:

> This is a patient whom I am very familiar with who has Kartagener's syndrome resulting in chronic sinusitis, bronchiectasis, psoatis and bursa totalis. He got subsequent airway impairment and *he does probably, in my opinion, have underlying black lung as well.* He also has a history of heart disease, paroxysmal atrial fibrillation, in addition to sleep apnea, reflux and hypertension….

DX 12, 2/20/03 Discharge Summary (emphasis added).

On March 4, 2003, Dr. Jordan stated that Claimant was seen in follow-up to his hospitalization for bronchiectasis, exacerbated by bacterial infection of pseudomonas aeruginosa. Dr. Jordan, again, noted Claimant's history of underlying bronchospasm, atrial fibrillation, and Kartagener syndrome with situs inverses totalis and subsequent chronic sinus disease. He also reported inspiratory crackles but no wheeze on examination of the lungs. Furthermore, he reported qualifying exercise blood gas studies which demonstrated worsening gas exchange and confirmed significant pulmonary impairment due to lung disease. However, Dr. Jordan's only specific references to black lung consisted of the following notations:

> **SUBJECTIVE:**
> …He is applying for black lung benefits. He needs an exercise sat and gas. We have already done a CAT scan that showed the bronchiectasis. He has had a B-reader look at his film who confirmed that he has both asbestos, bronchiectasis and also black lung disease.
>
> …
>
> **PLAN:**
> 1. Discussed that I do feel that he has black lung disease superimposed on his other processes. I ran off a copy of the CT scan and the blood gas and sat to take with him for his black lung evaluation….

DX 12, 03/04/03 note.

On May 9, 2003, Dr. Jordan issued another note. On physical examination of the lungs, Dr. Jordan reported chronic inspiratory crackles, but no wheeze. In pertinent part, Dr. Jordan stated:

> **PROBLEMS:**
>
> 1. Bronchiectasis.
> 2. Prior history of colonization infections with *pseudomonas*.
> 3. Sinusitis.
> 4. Kartagener's syndrome with sinus inversus totalis.

DX 12, 5/9/03 note.

Mr. Bunch was hospitalized from August 11-13, 2003, for atrial fibrillation and chest pain. He was treated by Dr. Mukesh Sharma. Discharge diagnoses included bronchospastic airway disease and Kartagener's syndrome. EX 8.

On November 24, 2003, Dr. Arnold R. Hudson, Jr., a certified B-reader and pulmonary specialist, examined the Claimant on behalf of the Employer, and reviewed his records. EX 6. In his report, dated November 24, 2003, Dr. Hudson noted that Claimant had a long history of chronic disease and was diagnosed with Kartagener's syndrome in the early 1970's at UT Medical Center. Furthermore, Claimant underwent bilateral thoracotomies with a removal of a lobe or more from each lung for bronchiectasis. Moreover, Dr. Hudson stated that Claimant had been treated by Dr. Jordan, and his "records indicate that in addition to bronchiectasis from his Kartagener's syndrome the patient has some coal-workers pneumoconiosis (category I)." Dr. Hudson also noted that Claimant had exertional dyspnea and slight chest pain, and a history of multiple hospitalizations for exacerbations of his lung disease. Dr. Hudson also reported the following past medical/surgical history:

1. Kartagener's with bronchiectasis and paroxysmal atrial fibrillation.
2. Chronic sinusitis.
3. Hernia repair.
4. Left lower and middle lobectomy 1972 and right lower lobectomy in 1973.
5. Sinus surgery including bilateral antral windows 1973, 1988 and 1992.
6. Recent placement PE tubes in ears.
7. Colon polyps removed in 1988.
8. Multiple cysts removed from arms in 1995 and 1996.
9. Hernia Repair 1988.

Dr. Hudson also set forth Claimant's injuries, allergies, social and occupational history, family history, review of systems, findings on physical exam, and clinical test results. In pertinent part, Dr. Hudson stated that Claimant calculated the he worked as a coal miner for 16 years, but that he was credited for 13.5 years ending in 1988, and that the time Claimant spent in strip mines and underground mining was amount equal. Claimant "estimates he smoked a total of ten-years." Claimant reportedly started smoking in high school, quit in 1982, resumed smoking in 1985 or 1986, and quit again 7 or 8 years ago. Physical findings on chest examination were as follows: "Bilateral thoracotomy scars as well as some scars from chest tube wounds. Respiratory effort unlabored. Normal percussion and palpation. Bilateral rhonchi that clear with cough, breath sounds are a little diminished overall with probably some increased expiratory time." Dr. Hudson also conducted various clinical tests. The chest x-ray was interpreted as negative for pneumoconiosis by Dr. Wheeler. On pulmonary function studies, the "spirometry revealed severe airway obstruction…Lung volumes demonstrate reduced total lung capacity from air trapping…Diffusing capacity is moderately reduced. In addition, Dr. Hudson reviewed extensive outside records. In summary, Dr. Hudson stated:

IMPRESSION:

1. Severe chronic lung disease multifactorial including:
   a. Obstructive lung disease from bronchiectasis secondary to Kartagener's syndrome, and smoking related COPD.
   b. Restrictive ventilatory impairment from bilateral pulmonary resections.
   c. Possibly some pulmonary fibrosis from his bronchiectasis.
2. Kartagener's syndrome including chronic sinusitis.
3. Paroxysmal atrial fibrillation.

DISCUSSION: This patient has obvious advanced airway disease as a consequence of his bronchiectasis and prior smoking. He is totally and permanently impaired for all types of employment by his lung disease. I do not find that his coal mining exposure played any significant role in the causation of his lung disease.

EX 6.

Total Pulmonary or Respiratory Disability

As noted above, in the previous claim, Judge Neal found that the Claimant was totally disabled by a pulmonary or respiratory impairment, but the Employer and the Director, OWCP, have contested that issue in the current claim. A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2004). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2004).

In the current claim, all of the pulmonary function studies (taken May 9, 2002, August 23, 2002, April 4, 2003, May 13, 2003, and November 24, 2003) resulted in values qualifying for disability.

The case file contains the results of arterial blood gas studies administered on August 23, 2002 (resting), March 4, 2003 (resting), April 4, 2003 (resting and exercise), and November 24, 2003 (resting and exercise). Of the four blood gas studies conducted at rest, only the March 4, 2003 test is qualifying. However, the two most recent resting blood gas studies (April 4, 2003, and November 24, 2003) are only marginally above the qualifying criteria, and both of the exercise arterial blood gas studies taken on those dates yielded qualifying values.

Finally, all of the doctors who expressed an opinion on total disability (Drs. Baker, Dahhan and Hudson) agreed that Mr. Bunch is totally and permanently disabled by lung disease.

The evidence is compelling, and I find, that Mr. Bunch is totally disabled by a pulmonary or respiratory impairment. However, Judge Neal found, and the Benefits Review Board

affirmed, that his disability was not caused by pneumoconiosis. In order to establish a change in conditions, and entitlement to benefits, Mr. Bunch must establish that he has pneumoconiosis, and that it caused his disability.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004). In this case, Mr. Bunch's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed

after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Bunch has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Bunch filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Several of the x-ray interpretations in evidence (readings of x-rays taken October 11, 1986, September 21, 1988, September 24, 1997, January 5, 1999, and February 14, 2003, reported in the "silent" column on the chart above) were given in connection with medical treatment and do not mention coal workers' pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the administrative law judge to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). Except for the 1986 x-ray, all reflect the presence of densities, interstitial disease, or parenchymal or pleural abnormalities. I find the 1986 x-ray to be negative for pneumoconiosis, but all of the others to be neither negative nor positive. There is one negative reading of the February 2003 x-ray by a B-reader, which, if admissible (*see* note 3 above) would also render that x-ray negative.

The remaining x-rays (taken May 9, 2002, August 23, 2002, April 4, 2003 and November 24, 2003) have all been read as both positive and negative by dually qualified readers, and are, at best, in equipoise. The August 2002 x-ray has also been read as negative by a B-reader, and thus negative readings predominate for that one x-ray. Even according equal weight to the conflicting interpretations, the Claimant cannot meet his burden of establishing the existence of pneumoconiosis by a preponderance of the x-ray evidence.

I must next consider the medical opinions and other evidence, including the CT scan. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2004). The Sixth Circuit has interpreted this rule to mean that

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted). In this case, Mr. Bunch identified Dr. Jordan as his current treating physician.

The CT scan does not support a finding of pneumoconiosis. Although Dr. Prater did not expressly address the pneumoconiosis issue, his CT scan interpretation set forth diagnoses other than pneumoconiosis; namely, situs inversus and bronchiectasis compatible with Kartagener's syndrome. Moreover, Dr. Scatarige, a B-reader and Board-certified radiologist, expressly found no evidence of coal worker's pneumoconiosis or silicosis. Furthermore, Dr. Scatarige also listed situs inversus and bronchiectasis compatible with Kartagener's syndrome among his CT scan

findings. Accordingly, I find that the CT scan evidence, taken as a whole, is negative for pneumoconiosis.

The treatment records of the University of Tennessee Medical Center (DX 13; EX 1), East Tennessee Pulmonary Associates (DX 13), Methodist Medical Center (DX 13; EX 8), and Stone Mountain Health Services (CX 3) confirm the Claimant's testimony that he has a long history of health problems, including some associated with his lungs and his heart. Most of that evidence pre-dates the final denial of the most recent prior claim (DX 13; EX 1). Although some of the records contain occasional references to COPD and/or "coal workers pneumoconiosis by history" (s*ee, e.g.,* CX 3), such references do not constitute reasoned or documented findings of pneumoconiosis. Moreover, neither COPD nor coal workers' pneumoconiosis were even listed among the ten discharge diagnoses reported in the recent Discharge Summary from Methodist Medical Center, dated August 11, 2003 (EX 8). Furthermore, none of these treatment records address what caused Mr. Bunch's pulmonary disability, which was the element cited by the Benefits Review Board, in its final denial of the prior claim (DX 1). Therefore, for the purpose of my threshold analysis of this subsequent claim under Section 725.309, the above listed treatment records are accorded little weight. The more relevant medical opinion evidence consists of the recent opinions of Drs. Baker (DX 10), Dahhan (DX 13; EX 10), Jordan (DX 12), and Hudson (EX 6), summarized above. The crux of this case rests on the relative weight I accord to their opinions.

Based upon my analysis of the record, I accord greater weight to the opinions of Drs. Dahhan and Hudson than those of Drs. Baker and Jordan. In making this determination, I find that Dr. Baker's opinion is ambiguous and poorly reasoned regarding the "pneumoconiosis" and "causation" issues. As outlined above, Dr. Baker's reports are inconsistent. In one report, Dr. Baker attributed Claimant's COPD, chronic bronchitis, and hypoxemia to bronchiectasis, cigarette smoking, and coal dust exposure. On the other report, he attributed Claimant's impairment only to cigarette smoking and coal dust exposure. More significantly, Dr. Baker failed to provide the underlying rationale for his etiological findings. Furthermore, in the latter report, Dr. Baker answered "No" to a form question, indicating that Claimant does *not* have an occupational lung disease caused by coal mine employment.[5] Therefore, I accord Dr. Baker's opinion little weight.

Notwithstanding Dr. Jordan's status as Claimant's physician for more than ten years, and the fact that he treated the miner for multiple conditions, including pulmonary-related problems, I also accord Dr. Jordan's opinion little weight. As outlined above, Dr. Jordan's references to pneumoconiosis were sporadic, somewhat equivocal, and neither well-reasoned nor well-documented. He noted that Claimant "probably" has underlying black lung among various other pulmonary problems. Dr. Jordan cited the CT scan and an interpretation of an unspecified "film" by an unnamed B-reader, who reportedly confirmed that Claimant has "asbestos, bronchiectasis and also black lung disease." However, as discussed above, I have found that the CT scan evidence is negative, the x-ray interpretations given in connection with the claim are inconclusive, and none of the x-rays taken in connection with treatment in evidence in the

[5] In addition, I note Dr. Baker understated Claimant's cigarette smoking history, and his credentials in pulmonary medicine are unknown.

current claim have been read as positive for pneumoconiosis. Furthermore, in the records introduced in the previous claim, Dr. Jordan diagnosed pneumoconiosis on multiple chest x-rays. However, his opinion was outweighed by other interpretations by better-credentialed B-readers and Board-certified radiologists (DX 1, JUDGE Neal Decision and Order), and in any event, he was of the opinion that pneumoconiosis did not contribute to Mr. Bunch's pulmonary impairment. Moreover, Dr. Jordan's recent reports do not address the "causation" issue.

On the other hand, I find the opinions of Drs. Dahhan and Hudson to be well-reasoned and documented, and more consistent with the preponderance of the evidence, especially in light of the Claimant's extensive medical history of pulmonary problems, including the removal of significant portions of both lungs due to bronchiectasis, and Kartagener's syndrome, his relatively limited coal mine employment ending in 1988, and his cigarette smoking history which ended in 1997. In view of all these factors, I find that Claimant has failed to establish either clinical or legal pneumoconiosis under Section 718.202(a)(4), or by any other means.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that one of the applicable conditions of entitlement has changed since the denial of his previous claim became final, he is not entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The award of a representative's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Richard A. Bunch on June 13, 2002, is hereby DENIED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2004), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.